emailed validation letter 10/26/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 10.7.11
Amount $1800.-

Ck# 11430

I. IDENTIFICATION

Name Breathitt County Geriatric Corp. DBA Nim Henson Geriatric Center

Address 420 Jett Drive

City/County/Zip Jackson, Breathitt, 41339

Telephone number (606)666-2456 fbach@setel.com

Administrator Phillip Litteral

Date facility operation began at current address July 1972

Date facility began operation under current owner July 1972

RECEIVED
OCT 07 2011
OFFICE OF INSPECTOR GENERAL

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	120	120
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	Profit	Individual
County X	Nonprofit	Partnership
City		Corporation
Private		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

N/A

(OVER)

8/31

If facility owned or leased by a corporation, complete the following:

Name of corporation Breathitt County Geriatric Corporation

Address of corporation 420 Jett Drive

President or Chairman Arch Turner

Vice President Darrell Herald

Secretary _____

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	_____
_____	_____
_____	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

_____ Administrator 09/30/2011

Signature of authorized representative Title Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)